

CONFIDENTIAL

REQUEST FOR RESEARCH
Nursing Facility Providers (RUGs) Issues Only

Note that one Request for Information Form must be submitted for each resident about whom the facility has a question. The form must be faxed to Melissa Fritzman at (804) 371-4986. You will receive a response to this request within five working days from the date of your fax. HIPAA confidentiality requirements prohibit DMAS from accepting this information in any other format.

Facility Name: _____

Facility Medicaid Number: _____

Contact Name: _____ **Contact Phone:** _____

Contact email: _____ **Contact Fax:** _____

Please provide the following information as recorded on the MDS.

Resident Name (First, Last): _____

Resident Medicaid ID: _____ **Resident SSN:** _____

Resident DOB: _____ (mm/dd/yyyy)

Assessment Picture Date: _____

Issue: _____

For DMAS Use Only

Finding:

Date of Facility Notification:

CONFIDENTIAL